

<b>STATE OF MICHIGAN PROBATE COURT COUNTY OF</b>	<b>PETITION FOR MENTAL HEALTH TREATMENT</b> <input type="checkbox"/> <b>AMENDED</b>	<b>FILE NO.</b>
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In the matter of \_\_\_\_\_ **XXX-XX-**  
First, middle, and last name Last four digits of SSN

<small>Court ORI</small>	<small>Date of birth</small>	<small>Place of birth</small>	<small>Race</small>	<small>Sex</small>
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1. I, \_\_\_\_\_, an adult \_\_\_\_\_ petition because  
Name (type or print) specify whether a relative, neighbor, peace officer, etc.  
 I believe the individual named above needs treatment.

2. The individual was born \_\_\_\_\_, has a permanent residence in \_\_\_\_\_  
Date  
 County at \_\_\_\_\_  
Street address City State Zip  
 and can presently be found at \_\_\_\_\_  
Facility name or other address

This petition is for a person who was found not guilty by reason of insanity in this county (NGRI).

3. I believe the individual has mental illness and
- a. as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.
  - b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.
  - c. the individual's judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

4. The conclusions stated above are based on
- a. my personal observation of the person doing the following acts and saying the following things:  
 \_\_\_\_\_  
 \_\_\_\_\_
  - b. the following conduct and statements that others have seen or heard and have told me about:  
 \_\_\_\_\_  
 \_\_\_\_\_

by: \_\_\_\_\_  
Witness name Complete address Telephone no.

(SEE SECOND PAGE)

Do not write below this line - For court use only

5. The persons interested in these proceedings are:

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
	Spouse		
	Guardian*		

\*(Specify the county where the guardianship was established and the case number.) \_\_\_\_\_

6. The individual  is  is not a veteran.

7. Attached is a  clinical certificate by a physician or licensed psychologist taken within the last 72 hours.  
 clinical certificate by a psychiatrist taken within the last 72 hours.  
 no clinical certificate is attached because only assisted outpatient treatment is requested.

8. (For hospitalization and combined treatment only.) An examination could not be secured because: \_\_\_\_\_

I request:

- a. the individual be examined at \_\_\_\_\_,  
the preadmission screening unit or hospital designated by the community mental health services program.  
 b. a peace officer take the individual into protective custody and transport the individual to \_\_\_\_\_

9. I request the court to determine the individual to be a person requiring treatment and to order:

- a. hospitalization only.  
 b. a combination of hospitalization and assisted outpatient treatment.  
 c. assisted outpatient treatment without hospitalization.

10. I request the individual be hospitalized pending a hearing.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

\_\_\_\_\_  
Signature of attorney

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (type or print)

Bar no.

\_\_\_\_\_  
Signature of petitioner

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, state, zip

Telephone no.

\_\_\_\_\_  
City, state, zip

\_\_\_\_\_  
Home telephone no.

\_\_\_\_\_  
Work telephone no.

FOR HOSPITAL USE ONLY	This petition for mental health treatment was received by the hospital on _____ at _____.
	_____ Date Time
_____ Signature of hospital representative	